The IME factor is calculated using Medicare methodology in effect for the federal fiscal year ending September 31, 1995, as follows:

$$[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1]1.89$$

The IME factor used for discharges in the rate year is based on the number of interns and residents and available beds reported in the most recent Medicare cost report filed with the Department as of December 31 of the year immediately preceding the rate year.

10-010.03B7 Calculation of Medicaid Capital Related Costs: Medicaid capital-related per diem costs are calculated from base year Medicare cost reports as follows:

1. Routine service capital-related costs - Medicaid routine service capital-related costs are calculated by allocating total hospital routine service capital-related costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed capital-related costs.
2. Inpatient ancillary service capital-related costs - Medicaid inpatient ancillary service capital-related costs are calculated by multiplying an overall ancillary capital-related cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary capital-related cost-to-charge ratio is calculated by dividing the sum of the capital-related costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers.
3. Total capital-related costs are equal to the sum of Medicaid routine service capital-related costs and Medicaid inpatient ancillary service capital-related costs.
4. Building and fixtures capital-related costs are calculated by multiplying total capital-related costs times a percentage determined by dividing total hospital building and fixtures costs by total hospital capital costs.
5. The capital-related per diem cost is calculated by dividing Medicaid building and fixtures capital-related costs by the sum of base year Medicaid acute care and bassinet patient days.

Capital costs are calculated by blending the hospital-specific costs per day with the peer group weighted median cost per day over an eight-year period, as follows:

Medicaid Rate Year	Hospital-Specific	Peer Group Weighted Median
July 1, 1995, through June 30, 1996	100.0%	0.0%
July 1, 1996, through June 30, 1997	87.5%	12.5%
July 1, 1997, through June 30, 1998	75.0%	25.0%
July 1, 1998, through June 30, 1999	62.5%	37.5%
July 1, 1999, through June 30, 2000	50.0%	50.0%
July 1, 2000, through June 30, 2001	37.5%	62.5%
July 1, 2001, through June 30, 2002	25.0%	75.0%
July 1, 2002, through June 30, 2003	12.5%	87.5%
July 1, 2003, through June 30, 2004	0.0%	100.0%

10-010.03B8 Calculation of Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the DRG.

10-010.03B9 Rebasing of Rates: Each prospective rate component will be rebased every three years. Rebasing will be calculated using the most recently finalized and filed cost report available at the time of rebasing for each facility.

10-010.03B10 Transfers: When a patient is transferred to or from another hospital, DSS shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

10-010.03B11 Inpatient Admission After Outpatient Services: A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a patient is admitted as an inpatient within three calendar days of the day that the hospital outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

10-010.03B12 Readmissions: NMAP adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All NMAP patients readmitted as an inpatient within 31 days will be reviewed by the PRO. Payment may be denied if either admissions or discharges are performed without medical justification as determined by the PRO.

10-010.03B13 Interim Payment for Long-Stay Patients: NMAP's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days.

To request an interim payment, the hospital shall send a completed Form HCFA-1450 (UB-92) for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to:

Medical Services Division
Hospital Program Specialist
P.O. Box 95026
Lincoln, NE 68509-5026

The hospital will be notified in writing if the request for interim payment is denied.

10-010.03B13a Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement "from" and "to" dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

10-010.03B14 Payment for Non-physician Anesthetist (CRNA) Fees: Hospitals which meet the Medicare exception for payment of CRNA fees as a pass-through by Medicare, will be paid for CRNA fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for CRNA services. Costs will be calculated using the hospital's specific anesthesia cost to charge ratio. CRNA fees must be billed using revenue code 964 - Professional Fees Anesthetist (CRNA) on the HCFA-1450 (UB-92) claim form.

10-010.03C Payment for Peer Group 4 (Excluded Rural Acute Care Hospitals): Payments for acute care and bassinet services for hospitals in peer group 4 are based on a prospective per diem rate. Separate rates are set for acute services and for bassinet services.

10-010.03C1 Calculation of Peer Group Base Payment Amount: The peer group base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year, adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year (in accordance with the methodology described in 471 NAC 10-010.03B2, #1, 2) per patient day. Per diem amounts are arrayed in descending order, and the peer group median is determined.

Hospital-specific acute per diem costs are determined by dividing the allowable acute care operating costs, including capital costs, by the number of acute care patient days in the base year.

Payment for each discharge is calculated by multiplying the peer group per diem rate times the number of PRO-approval patient days (see 471 NAC 10-010.11).

Hospital-specific bassinet per diem costs are determined by dividing allowable nursery operating costs, including capital-related costs, by the number of bassinet patient days in the base year.

Payment for each discharge is calculated by multiplying the peer group per diem rate by the number of bassinet patient days. Normal bassinet level of care for newborns (class of care 88) is exempt from PRO review.

Payment is made for the day of admission, but not the day of discharge.

10-010.03C2 Nursery Care: Based on PRO review (see 471 NAC 10-010.11), the Department may pay the acute hospital per diem rate if the newborn -

1. Is transferred from nursery care to acute care or intensive care; or;
2. Remains in the hospital after the mother's discharge, effective the date of the mother's discharge, if the child is being discharged to the mother's care.

When billing the Department for the acute per diem rate for a newborn, the hospital must use the acute level of care code (85) and the appropriate ICD-9-CM diagnosis code for the infant's illness.

Delivery room ancillary charges must be reflected on the mother's claim, not in the ancillary portion of a nursery claim.

If only the child is eligible for Medicaid, see 471 NAC 10-005.24.

10-010.03D Payments for Psychiatric Services: Payments for psychiatric discharges are made on a prospective per diem.

All psychiatric services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. The per diem will be the sum of -

1. The peer group base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of PRO-approved patient days.

Payment is made for the day of admission, but not the day of discharge.

Mental health and substance abuse services provided to clients enrolled in the NMMCP for the mental health and substance abuse benefits package will be reimbursed by the plan.

10-010.03D1 Calculation of Peer Group Base Payment Amount: The peer group base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year, adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year (in accordance with the methodology described in 471 NAC 10-010.03B3, #1, 2, 3) per patient day for all psychiatric free-standing hospitals and Medicare-certified distinct part units. Per diem amounts are arrayed in descending order, and the peer group median is determined.

10-010.03D2 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem (see 471 NAC 10-010.03B7).

10-010.03D3 Calculation of Direct Medical Education Per Diem Rate: Hospital-specific direct medical education costs reflect NMAP's average cost per patient day for approved interns and residents. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year, adjusted to reflect changes in the number of interns and residents reported in the most recent Medicare cost report filed with the Department, and adjusted for inflation using the MBI. To determine the direct medical education payment amount paid for each patient day, adjusted amounts are divided by the number of base year Medicaid psychiatric patient days.

10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of -

1. The peer group base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of PRO-approved patient days.

Payment is made for the day of admission but not for the day of discharge.

10-010.03E1 Calculation of Peer Group Base Payment Amount: The peer group base payment per diem is calculated as the median of the hospital-specific base year operating cost (in accordance with the methodology described in 10-010.03B3) per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units. Per diem amounts are arrayed in descending order, and the peer group median is determined.

10-010.03E2 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem (see 471 NAC 10-010.03B7).

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Effective for cost reporting periods beginning after July 1, 1999, payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Medicaid pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. The certification is required no later than one day before the date on which the bill for inpatient CAH services is submitted to NMAP. Certifications need not routinely be submitted with inpatient bills, but should be retained at the CAH and made available on request to NMAP.

Subject to the 96-hour limit on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients. The part of an inpatient stay that exceeds 96 hours will be covered if it is considered medically necessary, and the CAH documents either that transfer of the patient to a hospital is precluded because of weather or other emergency conditions, or a PRO or equivalent entity has, on request, waived the 96-hour restriction with respect to the specific case.

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: The Department shall determine if a hospital meets the definition of a disproportionate share hospital in 471 NAC 10-010.03A using the hospital's Medicaid inpatient utilization rate and low-income utilization rate. Inpatient days for out-of-state Medicaid patients will be included in the computation of each respective ratio if reported to the Department prior to the beginning of the Medicaid rate period.

10-010.03H1 Disproportionate Share Payment: The Department shall make a quarterly payment to each disproportionate share hospital for inpatient services other than bassinet care. The term "disproportionate share percentage" shall be equal to the applicable percentage as set out in Section 1886(d)(5)(F) and Section 1923 of the Social Security Act. The quarterly payment will be determined on a claim by claim basis from claims paid in the quarter. The d8isproportionate share payment is the applicable disproportionate share percentage, multiplied by the allowable payment amount, less applicable payments by other sources that exceed the original allowable amount.

NMAP will calculate a quarterly disproportionate share payment for services provided by NMMCP capitated plans from information provided by the plans. The disproportionate share payment will be determined by multiplying the applicable disproportionate share payment percentage times the amount NMAP would have paid under the fee for service payment system according to 471 NAC 10-010, Payment for Hospital Services.

No retroactive adjustment will be made to the disproportionate share rate. Payments to a hospital shall not exceed the hospital-specific amounts under OBRA 93. Total disproportionate share payment(s) may not exceed Nebraska's yearly disproportionate share allotment as determined and published by HCFA, including limits to IMDs and other mental health facilities. In the event that calculations for Nebraska hospital(s) exceed this amount, payment(s) shall be ratably reduced, proportionately based on DSH payment(s).

10-010.03H2 Disproportionate Share Psychiatric Hospitals: In addition to the disproportionate share adjustment described in 471 NAC 10-010.03H1, the Department shall make a disproportionate share adjustment, payable to the hospital in quarterly payments, to each disproportionate share psychiatric hospital that derives 25% or more of its revenues from State General Funds excluding Title XIX Medicaid funds. The amount of the adjustment payable under this paragraph shall be equal to two times the dollar amount of revenues derived from State General Funds during the interim rate period. This amount shall be decreased prorata should the disproportionate share payment made under 471 NAC 10-010.03H1 plus the payment adjustment described in this paragraph exceed the disproportionate share allotment set pursuant to the Medicaid Voluntary Contribution and Provider Specific Tax Amendment of 1991. The prorata reduction shall be equal to the ratio of a hospital's general fund revenue over general fund revenue of all hospitals qualifying under this paragraph times the amount by which general fund revenues plus amounts payable under 471 NAC 10-010.03H1 exceed the allotment.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals with 100 or more acute care beds located in Metropolitan Statistical Area (MSAs) as designated by Medicaid.
2. Other Urban Acute Hospitals: Hospitals with less than 100 acute care beds located in a Medicare-designated MSA and hospitals that have been redesignated to an MSA by Medicare;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in these regulations.
5. Rehabilitation Hospitals and Distinct Part Units: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in these regulations.

Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. The cost-to-charge ratio is the peer group average.

Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

The Department may allow payments to out-of-state hospitals for direct or indirect medical education costs at a negotiated per discharge rate.

10-010.03J1 Exception: The Administrator of the Medical Services Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in 471 NAC 10-010.03J only when the Medical Director of the Department has determined that -

1. The client requires specialized services that are not available in Nebraska; and
2. No other source of the specialized services can be found to provide the services at the rate established in 471 NAC 10-010.03J.

10-010.03K Out-of-Plan Services: When enrollees in the NMMCP are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are not required, but are authorized to pay providers of hospital inpatient services who care for individuals enrolled in the NMMCP at rates the Department would otherwise reimburse providers under this section.

10-010.03L Free-Standing Psychiatric Hospitals: When a free-standing psychiatric hospital (in Nebraska or out of state) does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service shall bill NMAP for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. The hospital's rate is calculated according to 471 NAC 10-010.03C, Computation of Rate and/or 10-010.03J, Out-of-State Hospitals. This is an exception to policies related to the elimination of combined billing in 471 NAC 10-003.04D and following.

10-010.03M Rate-Setting Following a Change in Ownership: The rate-setting process for facilities with a change in ownership will be the same as the rate-setting process used prior to the change in ownership as described in these regulations.

10-010.03N Rate-Setting for a New Operational Facility: The Department shall establish a prospective per discharge rate for a new operational facility for Peer Groups 1 - 7. The rate will be the average peer group rate for the respective peer group for the new facility. For critical access hospitals, the rate will be determined individually for each hospital on a cost basis system in accordance with Medicare rules. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals with 100 or more acute care beds located in Metropolitan Statistical Area (MSAs) as designated by Medicaid.
2. Other Urban Acute Hospitals: Hospitals with less than 100 acute care beds located in a Medicare-designated MSA and hospitals that have been redesignated to an MSA by Medicare;
3. Rural Acute Care Hospitals: All other acute care hospitals with 30 or more base year Medicaid discharges;
4. Excluded Rural Acute Care Hospitals: Hospitals with less than 30 Nebraska Medicaid discharges in the base year;
5. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the Nebraska Department of Health and distinct parts as defined in these regulations;
6. Rehabilitation Hospitals and Distinct Part Units: Hospitals that are licensed as rehabilitation hospitals by the Nebraska Department of Health and distinct parts as defined in these regulations.
7. Critical Access Hospital: Hospitals which (1) maintain no more than 15 inpatient beds, except as permitted for CAHs having swing-bed agreements; (2) are located outside any area that is a Metropolitan Statistical Area or that is recognized as urban; and (3) are certified by HCFA as a Critical Access Hospital.